

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-17

Subject: Ensuring Continuity of Care Protections during Active Courses of Treatment  
(Resolution 108-A-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee A  
(John Armstrong, MD, Chair)

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1 At the 2016 Annual Meeting, the House of Delegates referred Resolution 108, “Continued Surgical  
2 Care,” which was sponsored by the New York Delegation. The Board of Trustees assigned this  
3 item to the Council on Medical Service for a report back to the House of Delegates at the 2017  
4 Annual Meeting. Resolution 108-A-16 asked:

5  
6 That our American Medical Association (AMA) seek legislation/regulation which would allow  
7 a physician who has performed an initial surgical procedure, to continue to follow the patient  
8 and perform any necessary follow-up surgery, regardless of the physician’s change in  
9 participation status; and

10  
11 That any follow-up surgery performed by a physician whose participation status changed after  
12 the initial surgery was performed, be reimbursed appropriately based on their current  
13 participation status.

14  
15 This report provides background on health plan continuity of care processes; highlights the Health  
16 Benefit Plan Network Access and Adequacy Model Act of the National Association of Insurance  
17 Commissioners (NAIC); outlines continuity of care protections of marketplace, Medicare  
18 Advantage and Medicaid health plans; summarizes relevant AMA policy and model state  
19 legislation; and presents policy recommendations.

20  
21 **BACKGROUND**

22  
23 When patients transition between health plans, or when providers, including physicians, leave or  
24 are terminated from health plan networks, patients with usual sources of care face potential care  
25 disruptions due to the need to find new in-network physicians and hospitals. Such care disruptions  
26 can be especially detrimental to patients in the middle of a course of treatment.

27  
28 Some health plans have implemented continuity of care processes to prevent care disruptions for  
29 enrollees undergoing active courses of treatment. Health plan continuity of care processes can  
30 provide eligible new enrollees of a health plan undergoing an active course of treatment with a  
31 pathway to continue to receive care from non-participating providers accessed prior to health plan  
32 enrollment at in-network cost-sharing levels. For existing plan enrollees in an active course of  
33 treatment, continuity of care processes can provide a mechanism to access the care of providers no  
34 longer in the network at in-network cost-sharing levels. There are outlined time limitations for such  
35 continuity of care periods, which vary based on the health plan, physician discretion and patient  
36 needs. State and federal laws and regulations, and model laws, also provide parameters and

1 guidance for health plan continuity of care processes and protections. Ultimately, the goal of  
2 continuity of care processes is to transition affected plan enrollees to new in-network providers.

3  
4 NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS MODEL ACT

5  
6 The Health Benefit Plan Network Access and Adequacy Model Act of the NAIC,<sup>1</sup> which provides  
7 a model for state legislation and regulations, contains provisions to assure continuity of care  
8 protections for health plan enrollees in an active course of treatment whose provider leaves or is  
9 removed from the plan's network without cause. A health plan enrollee who has been treated on a  
10 regular basis by a provider removed from or leaving the network is considered under the model act  
11 to be in an active course of treatment. The following treatments and conditions meet the definition  
12 of "active course of treatment" under the model act:

- 13  
14 • An ongoing course of treatment for a life-threatening condition, defined as a disease or  
15 condition for which likelihood of death is probable unless the course of the disease or  
16 condition is interrupted;  
17  
18 • An ongoing course of treatment for a serious acute condition, defined as a disease or  
19 condition requiring complex ongoing care that the covered person is currently receiving,  
20 such as chemotherapy, post-operative visits or radiation therapy;  
21  
22 • The second or third trimester of pregnancy; and  
23  
24 • An ongoing course of treatment for a health condition for which a treating physician or  
25 health care provider attests that discontinuing care by that physician or health care provider  
26 would worsen the condition or interfere with anticipated outcomes.  
27

28 The act also states that when a provider of a health plan enrollee leaves or is removed from the  
29 network, the health plan should establish reasonable procedures to transition the plan enrollee in an  
30 active course of treatment to a participating provider in a manner that provides for continuity of  
31 care. In addition to providing the plan enrollee with notice of the provider leaving or being  
32 removed from the plan network, the model act states that the health plan also should make  
33 available to the patient a list of available participating providers in the same geographic area who  
34 are of the same provider type. Importantly, the model act stipulates that the health plan must  
35 provide information about how the plan enrollee may request to continue care with a provider that  
36 is no longer participating in the plan. The model act stresses that any health decisions made with  
37 respect to a request for continuity of care should be subject to the health benefit plan's internal and  
38 external grievance and appeal processes in accordance with applicable state or federal law or  
39 regulations. The care to be continued must also be medically necessary.  
40

41 Time limitations for the continuity of care period for health plan enrollees undergoing an active  
42 course of treatment are also outlined in the model act. Under the model act, the period should  
43 extend to the earlier of:

- 44  
45 • The termination of the course of treatment by the covered person or the treating provider;  
46  
47 • A time period determined by the state, while noting that the current accreditation standard  
48 for the length of the continuity of care period is 90 days, unless the health plan's medical  
49 director determines that a longer period is necessary;

- 1 • The date that care is successfully transitioned to a participating provider; or
- 2
- 3 • Benefit limitations under the plan are met or exceeded.
- 4

5 For health plan enrollees who are in their second or third trimester of pregnancy, the model act  
6 stipulates that the continuity of care period should extend through the postpartum period. Twenty-  
7 nine states have laws consistent with this provision of the model act.<sup>2</sup>

8  
9 Under the model act, granting continuity of care requests is contingent upon the provider accepting  
10 certain payment and billing parameters. First, the provider must agree in writing to accept the same  
11 payment from and abide by the same terms and conditions with respect to the health plan for that  
12 patient as provided in the original provider contract. Second, the provider must agree in writing not  
13 to seek any payment from the health plan enrollee for any amount for which the enrollee would not  
14 have been responsible if the physician or provider were still a participating provider.

## 15 16 HEALTH PLAN CONTINUITY OF CARE PROTECTIONS

### 17 18 *Health Insurance Marketplaces*

19  
20 The final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017 purposefully  
21 aligns with the NAIC model act. The final rule included a new continuity of care protection for  
22 patients enrolled in plans in federally facilitated marketplaces (FFMs) undergoing an active course  
23 of treatment. The rule requires health plans participating in FFMs, in cases where a provider is  
24 terminated without cause, to allow a health plan enrollee in an active course of treatment to  
25 continue treatment until the treatment is complete or for 90 days, whichever is shorter, at  
26 in-network cost-sharing rates. The regulation used the definition of “active course of treatment”  
27 included in the NAIC model act, and added that ongoing treatments for mental health and  
28 substance use disorders also fall within the definition.<sup>3</sup>

29  
30 Addressing physician payment and balance billing, the Center for Consumer Information and  
31 Insurance Oversight (CCIIO) of the Centers for Medicare & Medicaid Services (CMS) stated in its  
32 2017 letter to issuers in FFMs that it expected health plans to negotiate with a provider for payment  
33 of services under the new continuity of care protection. However, if a provider agrees to provide  
34 continuity of care under this new requirement, health plans in FFMs would only be responsible for  
35 paying a provider what was previously paid under the same terms and conditions of the provider  
36 contract, including any protections against balance billing. That being said, CCIIO also stated that  
37 it cannot require non-contracted providers to accept a particular payment rate, and as such, cannot  
38 prohibit balance billing for non-contracted providers.<sup>4</sup>

39  
40 As outlined in the final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017  
41 and subsequent letters to issuers in FFMs, the new continuity of care standards for FFMs are not  
42 intended to, and do not, preempt state provider transition notices and continuity of care  
43 requirements, and CMS intends to defer to a state’s enforcement of substantially similar or stronger  
44 standards.<sup>3,4,5</sup> As of April 2016, 39 states and the District of Columbia have continuity of care  
45 standards similar to those outlined in federal rules. However, the length of the continuity of care  
46 protection varies from state to state. Sixteen states extend continuity of care protections to enrollees  
47 that have switched to a new health plan, which is stronger than current federal rules. Eleven states  
48 do not have continuity of care protections as defined in the federal rule, but patients enrolled in  
49 plans offered through FFMs in some of these states will still have some continuity of care  
50 protections.<sup>2</sup> To review the status of continuity of care protections by state, please refer to  
51 <http://www.commonwealthfund.org/publications/blog/2016/apr/continuity-of-care-protections>.

1 *Medicare Advantage*

2  
 3 Continuity of care protections for patients enrolled in Medicare Advantage (MA) plans are largely  
 4 limited to cases of significant no-cause provider terminations. CMS has stated that, as a best  
 5 practice, MA plans should include certain information in notices to health plan enrollees in addition  
 6 to identifying the provider(s) being terminated from the network, including names and phone  
 7 numbers of in-network providers that enrollees may access for continued care, and information  
 8 regarding how enrollees may request continuation of ongoing medical treatment or therapies with  
 9 their current providers. CMS has stated that in the case of significant no-cause provider  
 10 terminations, it may be necessary for MA plans to allow care to continue to be provided on an  
 11 interim, transitional basis, by providers who have been terminated from the network in order to  
 12 address continuity of care needs of affected enrollees. In addition, MA plan enrollees substantially  
 13 affected by a significant no-cause provider termination during a plan year may be afforded a  
 14 special election period, so they can switch plans prior to the next open enrollment period.<sup>6</sup>

15  
 16 *Medicaid*

17  
 18 Under Medicaid, states are required to have a transition of care policy in effect to ensure continuity  
 19 of care during Medicaid program transitions when an enrollee, in the absence of continued  
 20 services, would suffer serious detriment to their health or be at risk of hospitalization or  
 21 institutionalization. The transition of care policy would be applicable during a transition from a  
 22 Medicaid fee-for-service program to a Medicaid managed care plan, or a transition from one  
 23 Medicaid managed care plan to another. The transition of care policy must ensure that enrollees  
 24 have access to services consistent with the access they previously had, and are permitted to retain  
 25 their current provider for a period of time if their providers are not in the Medicaid managed care  
 26 plan's network. In addition, enrollees must be referred to appropriate providers of services that are  
 27 in the network.<sup>7</sup>

28  
 29 RELEVANT AMA POLICY AND ADVOCACY

30  
 31 Policy H-285.952 states that patients should have the opportunity for continued transitional care  
 32 from physicians and hospitals whose contracts with health plans have terminated for reasons other  
 33 than loss of/restrictions on their licenses/certifications or fraud. The policy states that patients  
 34 eligible for transitional care should specifically include, but not be limited to those who are:  
 35 undergoing a course of treatment for a serious or complex condition, undergoing a course of  
 36 institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the  
 37 time that they receive notice of the termination. The policy stipulates that transitional care should  
 38 be provided at the physicians' and hospitals' discretion, and should continue for an appropriate  
 39 length of time. Physicians and hospitals also should continue to receive payment for the services  
 40 provided during this transitional period. Policy H-285.924 states that health plans should continue  
 41 to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss  
 42 of/restrictions on their medical licenses/certifications or fraud, until a new printed directory is  
 43 distributed. Policy H-385.936 advocates for appropriate reimbursement for follow-up care of  
 44 complications and staged procedures from payers, including state and federal agencies.

45  
 46 In addition, Policy H-285.952 states that when a participating physician leaves a managed care  
 47 plan, patients of the physician be informed, in a timely manner, of the departure by the physician  
 48 and/or the managed care plan, and, if applicable, of their right to elect continued transitional care  
 49 from that physician. Policy H-285.908 supports requiring provider terminations without cause be  
 50 done prior to the enrollment period, thereby allowing enrollees to have continued access

1 throughout the coverage year to the network they reasonably relied upon when selecting and  
2 enrolling in a health insurance plan.

3  
4 Based on existing AMA policy, the AMA has model state legislation addressing network access  
5 and adequacy, which contains provisions to assure continuity of care protections for health plan  
6 enrollees in an active course of treatment. These provisions of the model bill largely align with  
7 those contained in the NAIC model act. In the arena of provider payment, like the NAIC model bill  
8 AMA's model state legislation underscores that granting continuity of care requests is contingent  
9 upon the provider accepting certain payment and billing parameters. While the NAIC model act  
10 states that the provider must agree in writing to accept the same payment from and abide by the  
11 same terms and conditions with respect to the health plan for that patient as provided in the original  
12 provider contract, the AMA model bill builds upon this language and states that the provider can  
13 also accept new payment and terms agreed to by the provider and health plan.

#### 14 15 DISCUSSION

16  
17 The Council believes that additional measures are needed to prevent disruptions in care for patients  
18 in an active course of treatment, both for new enrollees in a health plan, and existing enrollees  
19 receiving care from providers whose contracts with health plans have terminated for reasons other  
20 than loss of or restrictions on their licenses and/or certifications, or fraud. As an underlying  
21 principle, as outlined in Policy H-285.911, health insurance provider networks should be sufficient  
22 to provide meaningful access to all medically necessary and emergency care, at the preferred,  
23 in-network benefit level, on a timely and geographically accessible basis. Overall, patients,  
24 including those in an active course of treatment, should have continued access throughout the  
25 coverage year to the network they reasonably relied upon when selecting and enrolling in a health  
26 insurance plan. To achieve that goal, the Council recommends reaffirming Policy H-285.908,  
27 which supports requiring that provider terminations without cause be done prior to the enrollment  
28 period. In cases in which provider terminations without cause happen over the course of the  
29 coverage year, the Council also recommends the reaffirmation of Policy H-285.952, which states  
30 that patients should have the opportunity for continued transitional care from physicians and  
31 hospitals whose contracts with health plans have terminated for reasons other than loss of or  
32 restrictions on their licenses and/or certifications, or fraud.

33  
34 The Council proposes the modification of Policy H-285.924[4] to ensure that health plans continue  
35 to cover services provided by physicians who involuntarily leave a plan without cause, until the  
36 provider directory is updated online and a new printed directory is distributed. This amendment to  
37 Policy H-285.924 not only provides needed updates to the policy to account for the existence of  
38 online provider directories, but the proposed new wording of the policy would provide patients in  
39 an active course of treatment with strong continuity of care protections. To ensure physician  
40 payment for any transitional care associated with complications and staged procedures is adequate,  
41 the Council recommends modifying Policy H-385.936, which currently only advocates for  
42 appropriate payment for follow-up care in such scenarios.

43  
44 The Council recognizes that current AMA policy addressing continuity of care for patients in an  
45 active course of treatment focuses on existing health plan enrollees receiving care from providers  
46 whose contracts with health plans have terminated for reasons other than loss of or restrictions on  
47 their licenses and/or certification, or fraud. Patients in an active course of treatment who switch to a  
48 new health plan should also have the opportunity to receive continued transitional care from their  
49 treating out-of-network physicians and hospitals at in-network cost-sharing levels. Following what  
50 is already outlined in Policy H-285.952, continued transitional care for new health plan enrollees  
51 should be provided at the physicians' and hospitals' discretion, and should continue for an

1 appropriate length of time. Such care should only be provided after payment terms have been  
2 agreed to with the health plan. Moving forward, the AMA should continue to provide assistance  
3 upon request to state medical associations in support of state legislative and regulatory efforts, and  
4 disseminate relevant model state legislation, to ensure continuity of care protections for patients in  
5 an active course of treatment – both for existing and new health plan enrollees.

## 6 7 RECOMMENDATIONS

8  
9 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
10 108-A-16, and that the remainder of the report be filed.

- 11  
12 1. That our American Medical Association (AMA) reaffirm Policy H-285.911, which states that  
13 health insurance provider networks should be sufficient to provide meaningful access to all  
14 medically necessary and emergency care, at the preferred, in-network benefit level on a timely  
15 and geographically accessible basis. (Reaffirm HOD Policy)
- 16  
17 2. That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations  
18 without cause be done prior to the enrollment period, thereby allowing enrollees to have  
19 continued access throughout the coverage year to the network they reasonably relied upon  
20 when selecting and enrolling in a health insurance plan. (Reaffirm HOD Policy)
- 21  
22 3. That our AMA reaffirm Policy H-285.952, which states that patients should have the  
23 opportunity for continued transitional care from physicians and hospitals whose contracts with  
24 health plans have terminated for reasons other than loss of or restrictions on their licenses  
25 and/or certifications, or fraud. (Reaffirm HOD Policy)
- 26  
27 4. That our AMA modify Policy H-385.936 by addition and deletion to read as follows:  
28  
29 Our AMA advocates for appropriate ~~reimbursement~~ payment for follow-up care of, and  
30 transitional care associated with, complications and staged procedures from payers, including  
31 state and federal agencies. (Modify HOD Policy)
- 32  
33 5. That our AMA modify Policy H-285.924[4] by addition to read as follows:  
34  
35 It is the policy of our AMA that health plans: ... (4) should continue to cover services provided  
36 by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their  
37 medical license/certification or fraud (i.e., with cause), until the provider directory is updated  
38 online and a new printed directory is distributed. (Modify HOD Policy)
- 39  
40 6. That our AMA support patients in an active course of treatment who switch to a new health  
41 plan having the opportunity to receive continued transitional care from their treating out-of-  
42 network physicians and hospitals at in-network cost-sharing levels. Transitional care should be  
43 provided at the physicians' and hospitals' discretion. (New HOD Policy)
- 44  
45 7. That our AMA continue to provide assistance upon request to state medical associations in  
46 support of state legislative and regulatory efforts, and disseminate relevant model state  
47 legislation, to ensure continuity of care protections for patients in an active course of treatment.  
48 (Directive to Take Action)

Fiscal Note: Estimated at \$5,000.

## REFERENCES

<sup>1</sup> National Association of Insurance Commissioners. Health Benefit Plan Network Access and Adequacy Model Act. November 2015. Available at: <http://www.naic.org/store/free/MDL-74.pdf>.

<sup>2</sup> Corlette, S, Williams, A and Lucia, K. Obama Administration Moves Forward with New Continuity of Care Protections—How Will They Affect Existing State Laws? The Commonwealth Fund. April 13, 2016.

Available at: <http://www.commonwealthfund.org/publications/blog/2016/apr/continuity-of-care-protections>.

<sup>3</sup> Centers for Medicare & Medicaid Services. 45 CFR Parts 144, 147, 153, et al. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule. March 8, 2016.

Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

<sup>4</sup> Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. 2017 Letter to Issuers in the Federally-facilitated Marketplaces. February 29, 2016. Available at:

<https://www.cms.gov/cciiio/resources/regulations-and-guidance/downloads/final-2017-letter-to-issuers-2-29-16.pdf>.

<sup>5</sup> Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. 2018 Letter to Issuers in the Federally-facilitated Marketplaces. December 16, 2016. Available at:

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.

<sup>6</sup> Centers for Medicare & Medicaid Services. Medicare Managed Care Manual: Chapter 4 - Benefits and Beneficiary Protections. April 22, 2016. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>.

<sup>7</sup> Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. May 6, 2016. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.